
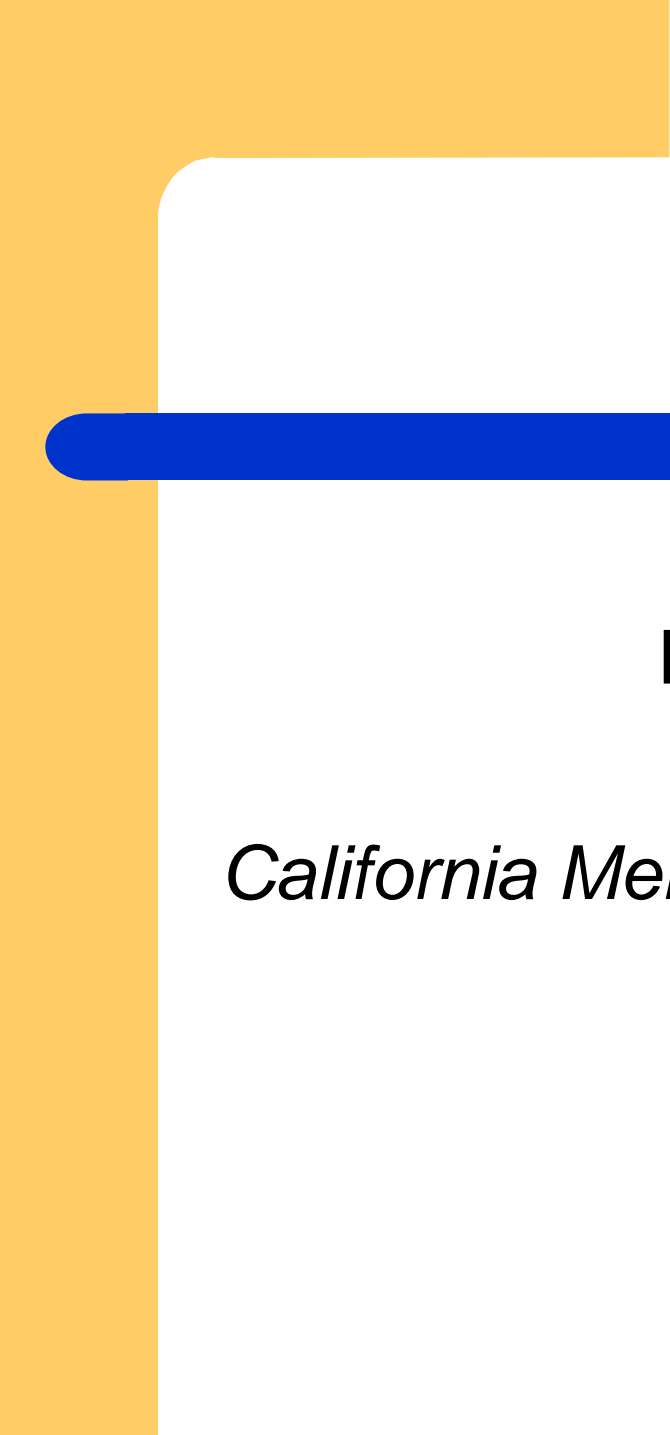


# California Mental Health Financing 101

The Mental Health  
Services Act in the Context  
of  
Overall County Mental  
Health Financing Pressures



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# Historical Perspective

- The California Community Mental Health Services Act 1969 was a national model of mental health legislation that “deinstitutionalized” mental health services, serving people with mental disabilities in the community rather than in state hospitals.

# Origins of the Community Mental Health System

- The Short-Doyle Act was the funding mechanism intended to build the community mental health system. Legislative intent language called for funding to shift from state hospitals to community programs.
- However, Governor Reagan vetoed such provisions in 1972 and 1973, so the state failed to distribute the savings achieved through the closures of state hospitals to the community mental health system.

# No Entitlement for Mental Health Services

- Unlike services to persons with developmental disabilities, the mental health system was never conceived as an “entitlement.”
- Mental health services were to be provided “to the extent resources are available.”
- This essential difference built rationing of services into the framework of mental health service delivery.

# Major Sources of Mental Health Funding Today

- Realignment Revenues
- State Categorical (AB 2034), AB 3632 and Medi-Cal EPSDT Funding
- Federal Funding (SAMHSA, Medi-Cal FFP)
- Mental Health Services Act (when funds are distributed, the MHSA will constitute about a 10 – 15 % increase in overall mental health funding)

# Community Mental Health System in Crisis

- Beginning with an inadequate funding base, state allocations to counties were severely diminished due to inflation throughout the 1970s and 80s.
- From 1982 to 1987 there were no cost of living or caseload adjustments to support community mental health.
- In 1990, California faced a \$15 billion state budget shortfall which would certainly have resulted in even more drastic cuts to mental health. Community mental health programs were already near collapse and overwhelmed with unmet need. This crisis propelled the enactment of Realignment.

# Realignment

- “Realignment” was enacted in 1991 with passage of the Bronzan-McCorquodale Act.
- Instead of community mental health being funded by the State General Fund, new “Realignment” revenues flow directly to counties.
- Realignment represented a major shift of authority from state to counties for mental health programs.



# Realignment Assigned Two Dedicated Funding Streams

- Realignment was given two dedicated funding streams:
  - ½ Cent Increase in State Sales Tax
  - State Vehicle License Fee
- From the start, revenues fell short of expectations due to the recession.

# Mental Health Programs That Were Realigned from the State to Counties

- All community-based mental health services
- State hospital services for civil commitments
- “Institutions for Mental Disease” which provided long-term nursing facility care

# Realignment Expanded to Public Health and Social Services

- Although it was begun as an effort to reform mental health financing, at the last minute pressure was exerted to expand Realignment.
- Public health programs and some social services (such as In-Home Supportive Services and Foster Care) were added to the Realignment formula.
- *Over time, this structure has contributed to many of the shortcomings of Realignment to keep pace with mental health needs.*

# Benefits of Realignment

- Realignment has generally provided counties with many advantages, including:
  - A stable funding source for programs, which has made a long-term investment in mental health infrastructure financially practical.
  - The ability to use funds to reduce high-cost restrictive placements, and to place clients appropriately.

# Benefits of Realignment

- Greater fiscal flexibility, discretion and control, including the ability to “roll-over” funds from one year to the next, enabling long-term planning and multi-year funding of projects.
- The emphasis on a clear mission and defined target populations under Realignment has allowed counties to develop comprehensive community-based systems of care, to institute best practices and to focus scarce resources on supporting recovery.

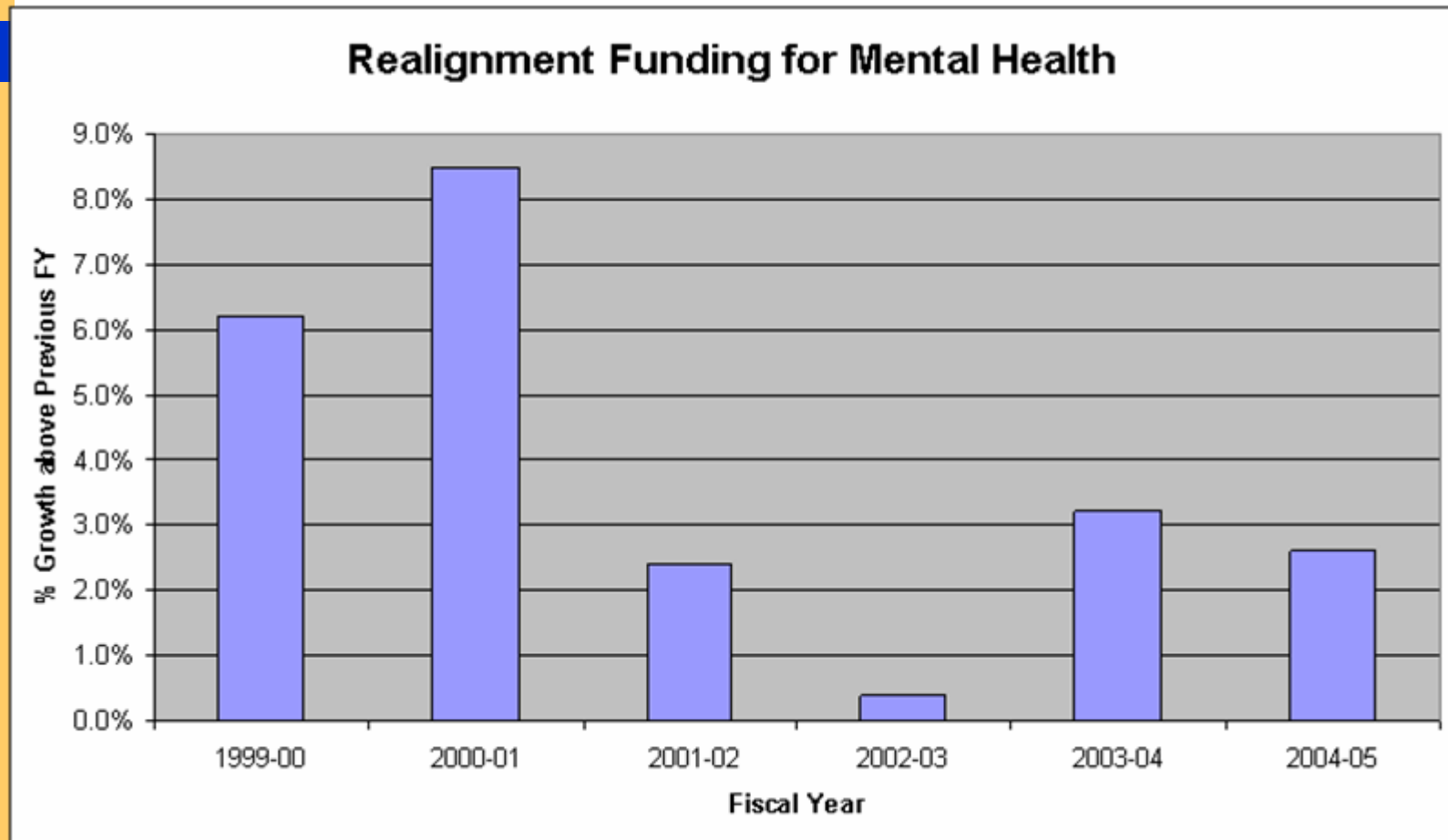
# Realignment Funds Distributed by Formula

- Annually, Realignment revenues are distributed to counties until each county receives funds equal to the previous year's total.
- Funds received above that amount are placed into growth accounts – Sales Tax and VLF.
- The distribution of growth funds is complex. However, it is a fixed amount annually and ***the first claim on the Sales Tax Growth Account goes to caseload-driven social services programs.***
- Any remaining growth from the Sales Tax Account and all VLF growth are then distributed according to a formula developed in statute.

# Realignment Formula Flawed – No Growth for Mental Health

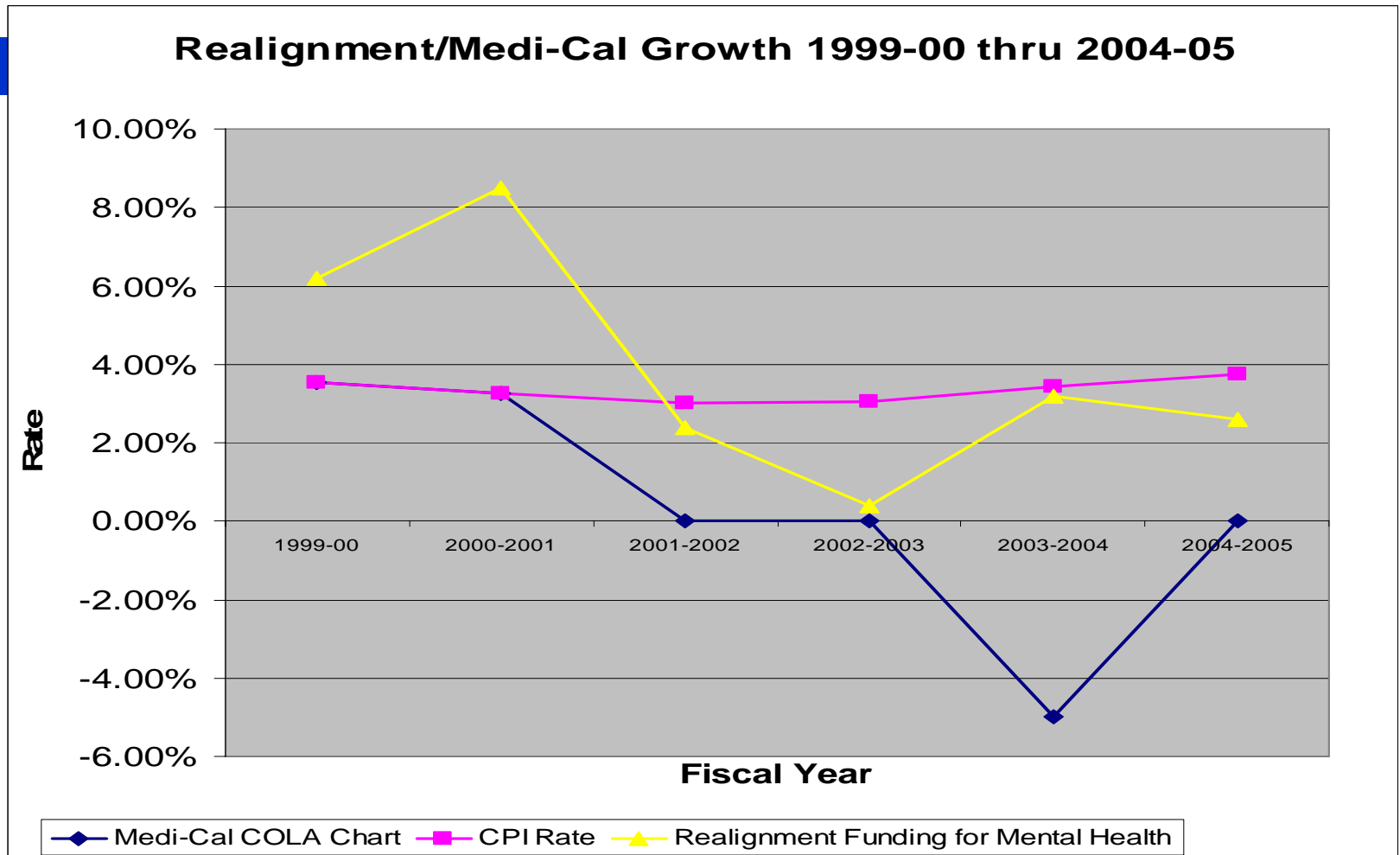
- Because the Realignment formula is weighted in favor of caseload-driven entitlement programs (In-Home Supportive Services and Foster Care), ***mental health has not received any Sales Tax growth in 4 years, and will not receive any for the foreseeable future.***
- VLF growth has only averaged 2.1% a year for the past 3 years.
- Meanwhile, costs of services and other demands steadily rise.

# Realignment Growth for MH -- Fiscal Year 1999/00 to 2004/05





# Realignment/Medi-Cal Growth 1999-00 thru 2004-05



# Medi-Cal Mental Health Services

- Federal Medicaid dollars constitute the second largest revenue source for county mental health programs, after Realignment.
- *Understanding the changes in California's Mental Health Medi-Cal program since Realignment and the interaction of Medi-Cal revenues with Realignment are critical to analyzing the current structure and status of public mental health services in California.*

# Counties Manage Medi-Cal Mental Health Services

- In 1971, counties agreed to take on responsibility for managing mental health services that the federal government requires the state to provide.
- Although managing the program involves substantial administrative obligations (which have only grown over time), the new program offered a better array of mental health services.
- It also gave counties the opportunity to “draw down” federal funds and therefore to serve more people.

# Medi-Cal Rehabilitation Option

- A Medicaid State Plan Amendment in 1993 added more services under the federal Medicaid “Rehab Option” to the scope of benefits, including:
  - Psychiatric health facility
  - Adult residential treatment
  - Crisis residential
  - Crisis intervention and stabilization
  - Intensive day treatment
  - Day rehabilitation
  - Linkage and brokerage
  - Mental health services
  - Medication support

# The Rehab Option

- The Rehab Option allows services that reduce de-institutionalization and help persons with mental disabilities live in the community.
- There have been recent federal discussions about cutting the Rehab Option, which would have a severe negative impact on the progress of transforming the mental health system.

# Medi-Cal Specialty Mental Health Consolidation

- From 1995 through 1998, a major shift in county obligations occurred with regard to the Medi-Cal program.
- The state consolidated programs into one “carved out” specialty mental health managed care program.
- This program operates under a federal Freedom of Choice waiver. Each Mental Health Plan contracts with DMH to provide medically-necessary specialty mental health services to the beneficiaries of the county.

# Medi-Cal Consolidation

- All Medi-Cal beneficiaries must receive their specialty mental health services through the County Mental Health Plan.
- General mental health care needs for Medi-Cal beneficiaries remain under the responsibility of the Department of Health Services, rather than DMH. DHS FFS is also responsible for all pharmaceutical costs for carve-out beneficiaries.

# Med-Cal and Realignment

- The state DHS transferred the funds that it had been spending under the FFS system for inpatient psychiatric and outpatient physician and psychologist services to county Mental Health Plans (MHPs). Counties are given the “first right of refusal” for taking on this new responsibility.
- It was assumed that MHPs would receive additional funds yearly beyond the base allocation for increases in Medi-Cal beneficiary caseloads, and for COLAs.
- Any costs beyond that allocation for the state match for Medi-Cal specialty mental health services were to come from county Realignment revenues.



# Impact of Medi-Cal on Realignment Funds

- Since Medi-Cal Consolidation, administrative requirements by DMH have grown dramatically.
- **Most importantly, counties have not received COLAs for the Medi-Cal program since 2000. In the FY 03/04 state budget, the Medi-Cal allocation to counties was actually reduced by 5% (\$11 million SGF).**
- Cumulatively, since FY 2000/01, counties have lost approximately \$51 million SGF (\$102 million with FFP) due to both the lack of a COLA, and the 5% reduction in 2003-04.
- The Governor's FY 2006-07 again proposes no COLA for this program. Increased program costs will once again be paid from Realignment funds.

# Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

- A lawsuit against the state in 1995 resulted in the expansion of Medi-Cal services to Medi-Cal beneficiaries less than 21 years of age who need specialty mental health services to correct or ameliorate mental illnesses, *whether or not such services are covered under the Medicaid State Plan*.
- As a result of the settlement, the state agreed to provide SGF to counties as the match for these expanded specialty mental health services. These services qualify under the EPSDT Medi-Cal benefit and are commonly referred to as EPSDT services.
- DMH developed an interagency agreement with DHS through which county mental health plans were reimbursed the entire non-federal share of cost for all EPSDT-eligible services in excess of the expenditures made by each county for such services during FY 1994-95.

# State Policy Shifts Part of EPSDT Costs to Counties

- In FY 2002-03, a 10% county share of cost was imposed by the Administration for EPSDT services above a baseline expenditure level. This means that counties must pay for 10% of all EPSDT services beyond a threshold level with funds from their Realignment account.

# AB 3632 – Special Education Services to Students

- The federal Individuals with Disabilities Education Act (IDEA) entitles all children with disabilities to a free, appropriate public education that prepares them to live and work in the community. IDEA entitlement includes mental health treatment for children and adolescents who are less than twenty-two years of age, have an emotional disturbance, and are in need of mental health services to benefit from a free and appropriate public education.
- ***These services are a federal entitlement, and children must receive services irrespective of their parents' income-level.***

## AB 3632 (Cont'd)

- The state Department of Education currently receives over \$1 billion annually from the federal government for implementing IDEA throughout the state, and for complying with all IDEA requirements.
- Prior to enactment of the state's FY 2002/03 budget, a total of \$12 million had been budgeted for counties statewide as categorical funding to pay for the services required under Chapter 26.5.
- Because the costs incurred by counties in providing those state-mandated services have far exceeded the categorical funding for many years, counties have been reimbursed for their additional costs through the SB 90 local mandate reimbursement process.

# AB 3632 Funding Issues

- In the FY 2002/03 state budget, the \$12 million of categorical funding for counties was **eliminated entirely**, and counties were told that they could receive all of their funding through the mandate reimbursement process.
- **However, the budget also placed a moratorium on mandate reimbursements for local government.**
- *The state currently owes counties over \$300 million in mandate reimbursement for this program alone.*
- *In most counties, the only revenue source available to pay for these services is Realignment revenues, which are meant to serve their “target population” – not Special Education Students.*

# Conclusion

- Realignment, which never fully funded mental health needs, was intended to grow over time. That growth has not occurred. In fact, Realignment does not keep up with the costs of providing services.
- Medi-Cal services managed by counties for the state have also not received cost of living adjustments, which constitutes a cost shift from the state to counties. Realignment funds must be used to pay for these increased costs.
- Failure of the state to fully reimburse counties for AB 3632 services has forced counties to re-direct Realignment funds away from their target population.

# Client Impacts

- **The mental health system in California was underfunded from the start.**
- **This system still serves only about 40% of persons with serious, disabling mental illness.**
- **California ranks near the bottom nationally in resources available for persons receiving Medicaid.**
- **Each year, the services that can be delivered erode under multiple demands on scarce dollars. Realignment funding has not kept pace with growth in population nor the consumer price index since it began.**



# Realistic Expectations

- While the MHSA will bring an exciting and much-needed infusion of new funds into California's public mental health system, it will not fix the structural financing problems counties face.
- It is inevitable that counties will need to reduce services in their non-MHSA systems, at the same time they are building new services under MHSA.
- Until these structural problems are addressed, the OAC and counties should work together to help "tell the story" to the public about our challenges and our victories.